Ministry of Health reports and other published literature. **RESULTS:** Out of 158,466 members who registered over the period under study (2005-2012), about 30% were active card-bearing members. The population coverage increased consistently from 6.4% in 2005 to 29.9% in 2012 with children below eighteen years of age as major membership driver, representing 42.2% of total membership. Membership is legally mandatory and household-based with children below eighteen years being automatically qualified when both parents are registered. The NHIS is largely tax-funded; extent of prepayment contributions declined over the study period from 20% to 15.4%. There is comprehensive one-for-all benefit package to ensure equity and adequate financial protection. The provider payment mechanism changed from fee-for-service in 2005 to Diagnostic Related Groupings (DRG) in 2008; although, fee-for-service is still used to pay for medicines supplied to insured members. In 2011, capitation payment was implemented for out-patient services at primary health centres. The administrative expenditure is relatively high; however, it declined over the study period from 42.1% in 2006 to 13.3% in 2012. **CONCLUSIONS:** The population coverage of the NHIS is increasing with a decreasing trend in administrative expenditure. Given that membership groups exempted from paying contributions represent more than fifty percent and extent of prepayment is declining, transfer of large scope of government subsidies would be necessary to ensure long-term financial viability.

PHS117

IMPACT OF HEALTH PLAN DESIGN AND KEY CHARACTERISTICS ON THE CHOICE OF CONTRACEPTIVE METHOD INITIATED AMONG WOMEN IN AN INTEGRATED HEALTH PLAN

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OBJECTIVES: Kaiser Permanente, Northern California integrated health plan (KPNC) offers non-deductible and deductible plans. This study examined whether having deductible vs. non-deductible plans impacts the types of contraceptives initiated, including long-acting reversible contraception (LARC) methods (intrauterine device, subdermal contraceptive implant), among women enrolled in KPNC plans. **METHODS:** Women aged 15-44 years who initiated a new contraceptive method in 2010 were identified from KPNC electronic databases. Key characteristics, including age, race/ethnicity, marital status, income, comorbidity status, and type of contraceptive method initiated, were determined and compared among women with deductible plans vs. those with non-deductible plans. Multivariable logistic regression analysis was utilized to identify characteristics associated with initiation of LARC methods. **RESULTS:** Of the overall study population, 9,062 eligible women had deductible plans and 59,877 had non-deductible plans. More women with non-deductible plans initiated highly effective methods (LARC, permanent contraception) compared with deductible plans (17.4% vs. 16.5%, p<0.0001). However, the frequency of LARC method initiation was 14.3% for both study groups and unaffected by plan type. After multivariable regression adjustment, the results were consistent, in that plan type did not influence initiation of a LARC method (deductible vs. non-deductible, odds ratio (OR): 0.97, p=0.36). Characteristics that influenced LARC method initiation included age, with women ≥40 years having greater odds (OR: 1.15, p<0.0001) and those ≤29 years having lesser odds than those aged 30-39 years for initiating LARC. Additionally, Hispanics vs. non-Hispanic whites (OR:1.10, p=0.0013), a <$50,000 income (OR: 1.08, p=0.001), having evidence of a comorbidity (OR: 1.30, p<0.0001), and having a health savings account (HSA) (OR: 1.16, p=0.0301) were associated with greater odds of initiating LARC methods. **CONCLUSIONS:** Among women enrolled in KPNC, the frequency of LARC method initiation was high, primarily influenced by factors including age, race/ethnicity, income level, and comorbidities, rather than differences in deductible versus non-deductible plans.

PHS118

MANAGEMENT OF HYPERTENSION IN DIABETICS BY PRIMARY CARE PHYSICIANS AND PREFERENCE OF ANTI-HYPERTENSIVE DRUGS

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OBJECTIVES: Primary care physicians (PCP's) are required to manage blood pressure (BP) below ≤130/80 mmHg among hypertensive diabetics. First-line anti-hypertensive drugs like ACE inhibitors/ARBs are preferred primary drugs in hypertensive diabetics as per guidelines. Thus the study examined hypertension management in diabetics, by maintaining BP ≤130/80 mmHg, among PCPs and anti-hypertensive drug preference among diabetics. **METHODS:** A cross-sectional study analysis on 2009-2010 National Ambulatory Medical Care Survey was (NAMCS) conducted. A bivariate chi-square analysis conducted between groups. Propensity score adjusted multiple logistic regression was conducted to examine which PCP is appropriately maintaining hypertension among diabetics. A Multinomial logistic regression analysis conducted to examine which drug is preferred among hypertensive diabetic patients. **RESULTS:** 45.66% of patient visits had BP ≤130/80 mmHg. No difference in hypertension management in diabetic visits among PCP's. There are 143% higher odds of prescribing diuretics compared to ACE inhibitors/ARBs among African American patient visits (OR: 2.438, 95%CI 1.360-4.369) as compared to Whites. Patient visits in Northeast region as compared to Midwest region has 65.5% (OR: 0.345, 95%CI: 0.154-0.771) lesser odds of receiving diuretic as compared to ACE inhibitors/ARBs. Unit increase in comorbidity index increases 63% odds of receiving beta-blockers (OR: 1.631, 95%CI: 1.092-2.436) and 59.9% odds of receiving diuretics prescription (OR: 1.599, 95%CI: 1.108-2.307) compared to ACE inhibitors/ARBs. **CONCLUSIONS:** BP managed in less than half diabetic patient visits. PCP's equally manage BP among hypertensive diabetics. Comorbidities should be managed well in order to manage hypertension in diabetics. African Americans are rightly prescribed diuretics compared to ACE inhibitors/ARBs as per the Seventh Report of the Joint National Committee (JNC7) guideline. As comorbidities increase, prescription of ACE inhibitors/ARBs decrease.

PHS119

PROVISION OF CULTURAL COMPETENCY TRAINING IN THE NATIONAL HOME AND HOSPICE CARE SURVEY: THE ROLE OF ORGANIZATIONAL AND LEADERSHIP FACTORS

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OBJECTIVES: To examine the role of organizational and leadership factors on cultural competency training (CCT) in home health and hospice care (HHH) agencies. **METHODS:** This observational study used data from the agency component of the 2007 Home and Hospice Care Survey (NHHCS). The final analytic sample had 828 agencies representing 12,107 HHH agencies when weighted. A summary CCT composite score was created based on three items supported by factor analyses (range= 0-3; alpha= 0.6): whether the agency provided mandatory training to understand cultural differences/beliefs that may affect delivery of services (referred to as CCT) to all administrative, clerical, and management staff; all direct service providers; and all volunteers. Institutional and resource dependency theories were used to predict associations between 12 organizational/leadership factors and CCT. Descriptive, correlational, and ordinal logit regression analyses were conducted, accounting for the complex sampling design/using finite population correction. Weighted estimates were obtained for the overall sample and subpopulations: home health (HH), hospice, and mixed agencies. **RESULTS:** HH, hospice, and mixed agencies comprised 75%, 15% and 10% of the sample, respectively. The overall mean CCT score was 1.7 (95%CI= 1.6-1.9). Regression results showed that JCAHO accreditation increased CCT odds in HH (OR= 2.1, 95%CI= 1.0-4.2) and hospice (OR= 4.4, 95%CI= 2.1-9.4) settings. Medical/social services increased CCT odds in HH (OR= 1.4, 95%CI=1.0-2.0) and hospice (OR=1.5, 95%CI=1.0-2.1) settings. Additionally, in HH, teaching status increased CCT odds (OR=2.7, 95%CI=1.2-6.2). In the hospice setting, formal contracts with outside organizations increased CCT odds (OR=4.0, 95%CI= 1.8-9.0), and non-for-profit status decreased CCT odds (OR=0.2; 95%CI=0.1-0.5). Administrator's tenure increased CCT odds in the mixed setting only (OR=1.1; 95%CI= 1.0-1.1). **CONCLUSIONS:** This study demonstrated the influence of organizational and leadership factors on CCT. HHH agencies need to increase their cultural competency practices to more effectively mitigate health disparities in this important community-based setting.

PHS120

AN EXAMINATION OF DISPARITY IN ACCESS TO MENTAL HEALTH SERVICES AMONG PEOPLE LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND CO-MORBID DEPRESSION IN ONTARIO

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OBJECTIVES: Depression is a common co-morbidity among people living with HIV. However, many HIV+ individuals are not diagnosed or not treated, which may result in poor HIV treatment outcomes and increased health care costs. We aimed to describe barriers and gaps in accessing mental health services among this high-need population in Ontario. **METHODS:** A retrospective cohort study was conducted from 2008-2012 by linking the Ontario HIV Treatment Network(OHTN) Cohort Study(N=3,545) with administrative health databases. Co-morbid depression was identified based on the Center for Epidemiologic Studies Depression Scale(Scores>=20) or the Kessler Psychological Distress Scale(Scores>=23). The use of primary and specialty mental health services was measured during the 12 months followed by the assessment of depression at the baseline. Logistic and negative binominal regression models were constructed to examine associations between predisposing, enabling, and need factors and the use and the intensity of the use of mental health services. **RESULTS:** 950(27%) were identified with co-morbid depression at the baseline. 523(55%) and 444(47%) had used the primary care and specialist care respectively during a year after they identified with co-morbid depression. Mean number of visits to primary and specialist mental health services were:6(SD=16) and 8(SD=18). For those who were depressed, we found that non-English speakers were two times less likely to use primary(aOR:0.5;95%CI:0.3-0.8) and mental health specialist(aOR:0.6;95%CI:0.4-0.9) services when compared to their English speaking counterparts. In addition, those who were identified as homosexual/gay, having annual income<$20,000 or residing in rural area were two times less likely to use mental health specialist care. For accessing primary and specialist care, we found that ethnic minorities or being homosexual/gay were likely to have 40-50% few encounters to care. **CONCLUSIONS:** Careful considerations with the impacts of language barriers, geographic restrictions, and cultural differences would be important to address in delivering successful mental health care for this high-need population in Ontario.

PHS121

IMPACT OF STATE CHILD AND ADOLESCENT PSYCHIATRIC WORKFORCE ON CAREGIVER REPORTED DIFFICULTY ACCESSING SERVICES FOR CHILDREN WITH MENTAL HEALTH CARE NEEDS

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OBJECTIVES: To examine the impact of state child and adolescent psychiatrists (CAP) workforce on caregiver reported difficulty accessing services for their child aged 3-17 years with any of these mental health conditions: autism spectrum disorder, cerebral palsy, Down syndrome, developmental delay, mental retardation, ADHD, anxiety, behavioral/conduct problems, or depression. **METHODS:** A